Parkview Sports Medicine

Consent to Treat

I hereby authorize medical treatment for said athlete at ______________________ (School Name) by the athletic trainers, physicians, and staff of Parkview Sports Medicine. A family member can be reached at ________________________ in the case that additional treatment or information is required. I understand that if the said athlete is seen by a physician at Parkview Sports Medicine and my insurance requires prior approval, I will be responsible for notifying my family physician.

Student Name ___________________________ Student Signature _____________________________________

Mailing Address _________________________ City/State/Zip ____

Date ___________________________________ Student Date of Birth __________________________________

Parent/Guardian Name ___________________ Parent/Guardian Signature ______________________________

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Authorization for Release of Medical Information

I also hereby authorize the release of any and all information regarding any medical treatment received by me for injury or illness while participating in athletics at said educational institution to that institution's Athletic Training staff, which consist of employees of Parkview Sports Medicine. I expressly authorize communications between the athletic trainer(s), or any designated member of the athletic training staff, and physicians at Parkview Sports Medicine, or any other physician or health care professional regarding my physical condition as it relates to my participation in athletics at said institution. I also authorize the athletic training staff to release said information to said institution's administration and to my current coaching staff for the purpose of informing them of my playing status.

If I am over 18: I authorize the athletic training staff to release my medical information to my parent(s)/guardian(s).

Parkview Sports Medicine employees may disclose information to the aforementioned individuals; however, this does not prevent those individuals from disclosing the information further, and Parkview Sports Medicine will not be held responsible for such further disclosure of information.

This authorization is valid until and unless revoked by me in writing. A photocopy of this authorization shall be considered as valid as the original.

Student Name ___________________________ Student Signature _____________________________________

Parent/Guardian Name ___________________ Parent/Guardian Signature ______________________________

Date ___________________________________

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Parkview Sports Medicine
HIPAA Privacy Receipt Acknowledgement

Parkview Sports Medicine ("PSM") Notice of Privacy Practices has been provided to me, or I have accessed it electronically. I understand I have the right to review the Notice of Privacy Practices prior to signing this document and by signing this document, acknowledge only that I have received PSM Notice of Privacy Practices. The Notice of Privacy Practices for PSM is also provided at the front desk at all PSM offices and on the PSM web site at www.parkview.com.

Parkview reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I am obtain a revised notice of privacy practices by accessing the PSM web site, calling PSM and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Student Name ___________________________ Student Signature _____________________________________

Parent/Guardian Name ___________________ Parent/Guardian Signature ______________________________

Date ___________________________________